Do Not Staple!

KENTUCKY EMPLOYEES' HEALTH PLAN
PY 2010
SPECIAL ENROLLMENT DUE TO TERMINATION OF MEDICARE SUPPLEMENT

Company Number

Reason for Application:

☐ Open Enrollment Due to Termination of Medicare Supplement

Only complete this form if you wish to change your 2010 Plan Year election on a Health Plan, HRA or Waiver

SECTION I: DEMOGRAPHIC INFORMATION → Please PRINT

Social Security Number

Date of Birth (MM/DD/YYYY)

NAME (First, MI, Last)

Mailing Address

City, State, Zip Code

County of Residence

Country / Mail Code, if not USA

Planholder's HOME Phone Number

Planholder's WORK Phone Number

Planholder's E-mail Address (prefer Work E-mail Address)

Hire Date

Employer Name

Work County

Smoking Status (Required)

Have you smoked in the last 2 months? ☐ Yes ☐ No

Gender
☐ Male
☐ Female

Marital Status
☐ Married
☐ Single

SECTION II: PLAN SELECTION → *If you wish to waive (i.e. decline) coverage, skip to Section V*

1. Option (Check only one)

☐ < Commonwealth Maximum Choice
☐ < Commonwealth Optimum PPO
☐ < Commonwealth Capitol Choice
☐ < Commonwealth Standard PPO

2. Level of Coverage

☐ < Single
☐ < Parent Plus
☐ < Couple
☐ < Family

3. Cross-Reference Payment Option
(Available for Family Coverage Only)

☐ < Yes

If Yes, you must complete Sections III and IV. The employee with the earliest hire date will be the policy holder.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you selected Single coverage, skip to Section VI*

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

Relationship Codes: SP = Spouse, CH = Child, CO = Court-Ordered Dependent, DD = Disabled Dependent

SECTION IV: CROSS-REFERENCE INFORMATION → *Complete ONLY if you checked Yes in Section II, Box 3*

Your Spouse's Company Number: ***(Required)***	Has your spouse smoked in the last 2 months? ***(Required)***	Is your spouse a Hazardous Duty Retiree?	Your spouse's Hire Date or Retirement Date:
_____	☐ ***Yes*** ☐ ***No***	☐ ***Yes*** ☐ ***No***	_____

Planholder's SSN

SECTION V: WAIVER → *Complete this section only if you did not select coverage in Section II*

Do you wish to waive (i.e. decline) your coverage and have the employer contribution of $175 per month deposited into a Health Reimbursement Account (HRA), ***if eligible***? *(If not eligible, you will be set up as a* ***Waiver, No HRA).*** ☐ ***Yes***
(Participants in the stand-alone, Waiver HRA will receive up to the maximum of $2,100 for the year.)

Humana*Access*℠ VISA® Debit Card
Upon enrolling in an HRA you will receive the Humana*Access*℠ Visa® card at no cost to you.

SECTION VI: AUTHORIZATION AND CERTIFICATION

I understand and agree that:

* My signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance and TPAs.
* **My spouse and I elect the cross-reference payment option, we are dual planholders with Family coverage and that upon a loss of eligibility by either spouse, the remaining planholder will have the option to enroll in either Single or Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.**
* Each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP Handbook.
* All benefits for myself and eligible dependents be provided in accordance with the plan document.
* I will abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* The elections indicated on this application may not be changed or canceled during the Plan Year, with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe.
* **I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Form or otherwise acknowledge post-tax treatment for my dependents; for Pre-tax treatment, dependent coverage must meet eligibility requirements of Section 152.**
* My Humana*Access*℠ Visa®Card will be suspended if the required HRA claim verification is not sent in within thirty (30) days after the Card swipe.
* This Plan reserves the right to deny access to the card, require repayment, deduct/withhold from your paycheck and offset your HRA if you fail to properly substantiate your HRA claims.
* This plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.

I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.
I acknowledge and understand that DEI will comply with the HIPAA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.
I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

_____ _____
Employee Signature **Date**

_____ _____
Spouse Signature – *REQUIRED* if electing the cross-reference payment option **Date**

Complete, sign and mail this form

Ky Employees' Health Plan
Department of Employee Insurance
501 High Street, 2nd Floor
Frankfort KY 40601

Form must be submitted by January 29, 2010